

Evidence Summary

Adult Mental Health Courts

What Are Mental Health Courts?

Mental health courts (MHCs) began as experimental, problem-solving courts to address the specialized needs of court-involved individuals with mental health disorders. Influenced by the success of adult drug courts, the judicial system established MHCs to divert accused persons from incarceration, and instead place them in court-supervised, community-based treatment services (Almquist & Dodd, 2009; Fisler, 2015; Hughes & Peak, 2012). This collaborative approach enables the criminal justice system and mental health system to address the needs of court-involved persons with mental illnesses (D'Emic, 2015). Defendants are typically eligible to participate in such courts if they suffer from a serious and persistent mental illness (D'Emic, 2015).

MHCs have been defined as a form of *therapeutic jurisprudence* (Wexler & Winick, 1991), designed to address the “criminalization of mental illness” (Skeem, Manchak, & Peterson, 2011, p. 111). Judges use their discretion to adjudicate therapeutic approaches for the mental health of the client and the best interests of the courtroom. The aim is to divert the court-involved individuals from traditional courts and to prevent recidivism – goals that address both the needs of the defendant and the overcrowded criminal justice system. The initial idea was to improve the mental health of the defendants (Fisler, 2015), but some have argued that MHCs fail to address the complex needs of persons with mental illnesses (Fisler, 2015) or an inadequate mental health system (Hughes & Peak, 2012).

By 2014, approximately 350 MHCs were in operation (Steadman et al., 2014). Currently, there is no standardized model for how MHCs operate (Anestis & Carbonell, 2014; Canada, Markway, & Albright, 2016), and court variations are based on the individual judge and jurisdiction. However, the common characteristics of most courts include 1) specialized court dockets with a non-adversarial, problem-solving approach to persons with mental illnesses; 2) judicially supervised treatment and community-based case management, recommended and designed by mental health professionals; 3) regular hearings that monitor progress and update a dedicated judge on the defendant's cooperation with the treatment plan; and 4) concrete definitions of success and failure of the treatment (Boothroyd, Poythress, McGaha, & Petrila, 2003; D'Emic, 2015; Hughes & Peak, 2012). Once the court-involved individual voluntarily chooses to participate in the mental health court process, compliance with the treatment plan is mandatory, and rewards and incentives often are used to motivate the participants to follow their individualized treatment plans (Dirks-Linhorst, Kondrat, Linhorst, & Morani, 2013; McNiel & Binder, 2007).

Origins and Population Served

Prior to the 1960s, persons with severe mental illness were usually hospitalized in psychiatric hospitals. The federally mandated deinstitutionalization of patients from hospitals back into the community triggered the eventual growth in the number of those with mental illness in the criminal justice system (Ennis, McLeod, Watt, Campbell, & Adams-Quackenbush, 2016; Rossman et al., 2012). By 2014, approximately 40 years after deinstitutionalization ended, close to 2 million mentally ill individuals were booked into the prison system on a yearly basis. Steadman et al. (2014) reported that the “rates of serious mental illness in U.S. correctional facilities are three to four times the rates in the general population” (p. 1100), and it has been estimated that 15 to 20 percent of people in jails or prisons or on parole have serious mental illnesses (Marlowe, Hardin, & Fox, 2016).

Problem-solving courts were created in the late 1980s to respond to the burgeoning number of justice-involved individuals with substance use disorders. The success of these adult drug courts in reducing the recidivism of these individuals prompted the development of MHCs a decade later. The first MHC was established in 1997 in Broward County, Florida, and described itself “explicitly as a treatment court” (Boothroyd et al., 2003, p. 56).

Most MHCs serve a population who have severe mental illnesses such as schizophrenia, bipolar disorder, major depressive disorder, schizoaffective disorder, PTSD, and often, co-occurring substance use disorder. Based on the parameters of individual courts, the population also may include persons with personality disorders, cognitive disorders, traumatic brain injury, dementia, or developmental disability (Fisler, 2015). Court-involved individuals who have co-occurring mental illness and substance use disorders are more likely than the general population to have a history of trauma both before and after the onset of the disorders (Steadman et al., 2013). Many have been exposed to childhood physical or sexual abuse, leading them to be especially vulnerable adults.

Gender and racial differences exist in the population of individuals involved in MHCs and the criminal justice system (Robertson, Swanson, Frisman, Lin, & Swartz, 2014). In both the general population and among persons with mental illness, men are more likely than women to commit crimes. However, women with serious mental illness are twice as likely as men to be incarcerated and more likely to have co-occurring substance use disorder. Compared with adults with mental illness alone, Robertson et al. (2014) found that adults with co-occurring disorders were significantly younger, more likely to be African American, and more likely to have bipolar disorder. In a large sample of prison inmates in New Jersey, African Americans were diagnosed with schizophrenia spectrum disorder more often than white and Latino persons, even though most persons involved in the MHCs were white males. (Sarteschi, Vaughn, & Kim, 2011).

MHCs vary regarding the eligible criminal offense as well as the mental illness of the court-involved individuals. Initially, courts only accepted individuals with misdemeanors or nonviolent offenses, but a growing number of courts now accept those who commit felony and violent offenses. Evaluation of recidivism between participants with felony versus misdemeanor offenses or violent versus nonviolent behavior suggests that MHCs can adequately address the needs and challenges of persons who commit more severe offenses (Anestis & Carbonell, 2014).

Implementation Context

Although MHCs have variations in their programs and the populations served, the Bureau of Justice outlined 10 *essential elements* about how a mental health court should be designed and implemented (Thompson, Osher, & Tomasini-Joshi, 2007). The *key components* that underlie drug courts served as a basis for the essential elements of MHCs. Two principles are central to each element: 1) the emphasis on collaboration among the related systems, such as criminal justice, mental health, and substance use treatment; and 2) the recognition that “MHCs are not a panacea” (Thompson et al., 2007, p. viii). That is, the mental health court is just one of a number of strategies that must be implemented to address the challenge of justice-involved persons with mental illnesses.

All 10 elements are not present in every MHC, but they serve as guidelines for program development and research on effectiveness (Thompson et al., 2007). These elements emphasize how to plan and administer an MHC; what the target population should be; how to identify participants and link them to services; how to establish clear, effective, and safe terms for participation; how participants receive informed choice regarding participation; how to link treatment supports and services; how to assure confidentiality; how the court team works collaboratively; how to monitor adherence to court requirements; and how to collect data to assure sustainability.

The different designs of MHC programs exemplify how courts variously interpret the elements proposed by the Bureau of Justice. For example, courts vary based on whether the cases are accepted at pre- or post-plea, or pre- or post-sentence; on how many weeks or months the community treatment lasts and who manages the care; and on whether jail is used as a sanction if the defendant does not follow the treatment plan. There are further variations in requirements or goals for completing the program, as well as differences in the final disposition of a successful case (Canada et al., 2016; DeMatteo et al., 2013; Fisler, 2015). Despite these variations, all MHCs focus on the outcome and process of the treatment, holding both the participants and service delivery system accountable (Fisler, 2015).

Best Practices

Once a defendant voluntarily enrolls in a mental health court, the participant is assigned to a multidisciplinary team, including a judge, prosecutor, and defense counsel, who coordinate care with the mental health providers. According to the Bureau of Justice’s essential elements on MHCs, treatment should include a wide range of community-based services and supports, combining counseling, medication, housing services, crisis intervention, peer supports, case management, and substance use treatment for defendants with co-occurring disorders (Thompson et al., 2007). The plan, ideally, is individualized and includes the input and buy-in of the participant. Additionally, caseloads of the mental health providers should be manageable in size. To ensure relapse prevention, case managers should work with the participants to provide a smooth transition from the program back into the community.

Using mixed methods to examine 11 MHCs in Oklahoma, Bullard and Thrasher (2014) created a grounded theory about best practices of successful courts, defined in part as those adhering

most to the 10 essential elements of MHCs (Thompson et al., 2007). Findings indicated that four successful courts, compared with seven unsuccessful ones, showed statistically significant crime reduction after MHC involvement. The best practices of the four successful courts had the following characteristics: 1) rapid placement of participants into proper programs; 2) effective collaboration among the full network of supervisors; 3) appropriate adaptation of programs to meet participants' needs; 4) provision of written reminders of court requirements; 5) availability of multiple treatment program options; 6) provision of transportation to treatment; 7) separation of compliant and noncompliant defendants in the courtroom; and 8) distribution of sanctions and incentives. Marlowe et al. (2016) reported that the successful courts in this study also followed effective practices required by *Adult Drug Court Best Practice Standards* (National Association of Drug Court Professionals, 2013, 2015).

Despite this one study examining best practices and publication of the 10 essential elements of MHCs, there is no comprehensive practice model or list of best practices followed by all MHCs (Hughes & Peak, 2012; Reich, Picard-Fritsche, Lebron, & Hahn, 2015; Sarteschi et al., 2011; Thompson et al., 2007). To lessen clinical symptoms, courts refer participants to psychiatrists or other doctors for medications (antipsychotics, antidepressants, and mood stabilizers), which physicians monitor on a frequent basis (Steadman et al., 2014). Many courts also refer participants to counseling and some form of case management such as assertive community treatment or integrated case management (Rossman et al., 2012), although neither of those programs are consistently offered or available. Some, but not all, courts provide additional resources to treat MHC participants with co-occurring substance use disorders to reduce their rearrest risk (Reich et al., 2015).

Although no universal, evidence-based practice model exists, preliminary evidence suggests that programs using cognitive-behavioral therapy (CBT) to address risk factors are more effective at reducing recidivism than psychiatric treatment without CBT (Skeem, Steadman, & Manchak, 2015). One challenge with CBT approaches, however, is that persons experiencing acute psychosis may be unable to cognitively alter their thoughts about procriminal behavior without the use of antipsychotic medications. Some studies have suggested that participants' positive outcomes may be linked more to the consistent relationships that develop between participants and court personnel and/or the participants' fear of sanctions and jail time, rather than to the actual mental health treatment (Hughes & Peak, 2012).

Lamberti (2016) suggested that effective collaboration between mental health and judicial professionals is central to best practices for defendants with mental illnesses. He called for improved mental health–criminal justice collaboration through all six stages of client treatment: engagement, assessment, planning and treatment, monitoring, problem solving, and transition. Regarding planning and treatment, Lamberti noted that mental health professionals usually address risk factors such as substance use, work or school problems, family or marital problems, and the lack of healthy recreational activities, but that there is still uncertainty about “who should address the problematic thinking that leads to antisocial behaviors” (p. 1209).

Evidence of Effectiveness

Overall Effectiveness

There are fewer studies on the effectiveness of MHCs, compared with the large body of research on drug courts, which has been studied for over 2 decades (Fisler, 2015). Hundreds of studies on drug courts have evaluated court designs, assessment procedures, use of incentives and treatment modalities, and the interactions between the participants and judge. In contrast, only a dozen MHCs have been studied to date, primarily in large urban areas, and the focus of the research has been limited (Fisler, 2015). Nevertheless, findings from these studies consistently indicate that MHCs “significantly reduce criminal recidivism compared to probation and other community-based dispositions for offenders with mental health disorders” (Marlowe et al., 2016, p. 28).

Based on recent studies, persons who participated in MHCs had fewer arrests after the program than prior to treatment; and they had fewer arrests, less serious offenses, and fewer days incarcerated than defendants in traditional courts (Case, Steadman, Dupuis, & Morris, 2009; DeMatteo et al., 2013; Fisler, 2015; Heilbrun et al., 2012). In their meta-analysis of 18 quasi-experimental studies, Sarteschi et al. (2011) also suggested that recidivism for participants was moderately reduced by mental health court involvement, but they acknowledged their research lacks “overall generalizability” in part “because there is no current standardized model of MHCs” (p. 19).

Several studies have examined the long-term effectiveness of the mental health courts, compared with treatment as usual (TAU). McNeil and Binder (2007) found that graduates of a San Francisco mental health court maintained reduced recidivism after ending court supervision. A study of the Bronx and Brooklyn mental health court systems reported reduced recidivism up to 2 years after discharge (Rossman et al., 2012). A longitudinal multisite study of four diverse MHCs in three different states reported MHC graduates had fewer arrests after 18 months than those receiving TAU and lower rearrest rates than participants who prematurely terminated MHC supervision (Steadman et al., 2011).

Based on the research to date, Steadman et al. (2011) suggested that “the appropriate question for MHCs is not, ‘do they work?’ but, ‘for whom, and under what circumstances do they work?’” (p. 171). For example, a significant finding from their multisite study was that MHC graduates who had better outcomes were those who had lower pre-18-month arrests and fewer days incarcerated, who had bipolar disorder rather than major depression or schizophrenia, and who did not have co-occurring substance use disorders. Further findings from this study suggested that clinical characteristics of the participants (such as treatment type, initial symptom severity, hospitalization history, medication adherence, insight into mental illness) were unrelated to recidivism or days of incarceration. A significant finding that emerged from another multisite, federally funded study (Case et al., 2009) was that persons with mental illnesses previously involved in the criminal justice system were at most risk for subsequent criminal involvement after a jail diversion program, which is similar to findings for non-mentally ill populations. A more recent study (Canada et al., 2016) highlighted the importance of viewing symptoms such as anxiety, depression, and guilt as contributing factors to compliance with court orders and treatment.

Fisler (2015) pointed out that the current body of research confirms that MHCs have a positive effect on recidivism, compared with regular courts, but studies fail to support the link from treatment to better mental health and improved public safety – a logic model and assumption that underpins mental health court design. For example, Lim and Day (2016) recently examined clinical improvement of psychiatric symptoms of MHC participants, but found that the courts were less effective on improving functioning and reducing mental health symptoms, though successful in reducing recidivism. A further examination of the relationship between psychiatric symptoms and MHC engagement suggests that symptomatology may be an important factor to consider when viewing recidivism, though not a causal explanation (Canada et al., 2016). Finally, as Reich et al. (2015) pointed out, there are still gaps in the literature and in researchers' understanding of the outcomes for MHC participants.

Cost-Effectiveness

MHCs are considerably more costly than traditional courts, because of the expense of expanded services (Marlowe et al., 2016). Fiscal policy is based on assumptions that MHCs can manage the needs of the population more efficiently than TAU, and reduced recidivism can lower overall justice system costs, potentially leading to cost savings for taxpayers. However, three studies have evaluated the cost-effectiveness of MHCs, and results are mixed. Two studies found their courts became cost-neutral or cost-beneficial only 2 to 3 years after the participant's program enrollment (Lindberg, 2009; Ridgely et al., 2007). In contrast, Steadman et al. (2014) found that participants in their multisite study averaged \$4000 more per person for all 3 years of follow up, compared with participants in TAU. High costs in the multisite program were attributed to the large number of participants with more days of incarceration prior to MHC enrollment and more participants with co-occurring substance use disorder and mental illness, resulting in complex treatment needs. Based on their study, the researchers stated that "broad claims of cost saving over time for MHCs as they currently operate are not supportable...the added treatment costs exceed for many participants the criminal justice cost savings" (p. 1103).

Future Research Directions

Because of the positive results on recidivism, a major direction for future research is to identify the specific populations and circumstances that produce positive outcomes. Research is beginning to focus on the predictive factors of recidivism such as prior criminal history and substance use (Fisler, 2015; Skeem et al., 2015; Steadman et al., 2014). However, as Skeem et al. noted (2011), “evidence-based mental health services (i.e., those that reliably affect clinical outcomes) have not affected criminal justice outcomes” (p. 114).

A new research emphasis is on developing and testing practice models that are directly linked to the risks and symptoms of individual participants. For example, Canada et al. (2016) stressed the importance of early treatment of co-occurring symptoms such as self-reported guilt, depression, and anxiety as variables in the recovery and recidivism of offenders with severe mental illnesses. They recommended the importance of longitudinal studies to evaluate how symptoms change across time for participants in MHC programs. Although treating psychosis is important, recognizing the influence of other symptoms may expand treatment to include compassion-based treatment, motivational interviewing, mindfulness, and a focus on interpersonal skills.

Skeem et al. (2011) proposed three priorities for future research regarding MHCs. First, they emphasized the need to identify and treat “the offenders for whom mental illness directly causes criminal behavior,” while recognizing that symptoms of psychosis are directly linked to “crime for only a fraction of offenders” (p. 120). These individuals need to be given evidence-based psychiatric treatment.

For the larger group of justice-involved persons whose mental illness is *not* directly linked to crime, a second research priority is to identify and expand evidence-based practices that effectively reduce recidivism (Skeem et al., 2011). CBT programs that build prosocial skills and reduce criminal thinking need to be tested for their effectiveness on this population. Expanded research on a risk-need-responsivity (RNR) model also is recommended, to evaluate programs based on matching the intensity of supervision and treatment with the level of the participant’s risk.

The third priority for future research is to assess and address bias regarding mental illness in the correctional system. Skeem et al. (2011) suggested that there is a “tendency to more closely watch offenders with mental illness and to more forcefully respond to their behavior,” which can result in inappropriate “incarceration to achieve social control” due to “fear and paternalism” (p. 122). In addition, racial bias in the correctional system should be examined. African American defendants reportedly have a higher risk of negative termination from MHCs, which raises questions about the cultural competence of treatment providers (Dirks-Linhorst et al., 2013).

A related, but more targeted focus for future research is on the examination of the risks and needs of offenders with diagnoses of both severe and persistent mental illness and substance use disorder (Peters, Kremling, Bekman, & Caudy, 2012; Steadman et al., 2013). Reportedly, three out of four detainees in jails have both serious mental illness and co-occurring substance

use disorder (Skeem et al. 2011), a higher rate than in the general population (Rojas & Peters, 2016). Rojas and Peters (2016) underscored the major treatment challenges for people with co-occurring disorders (CODs) because the combination substantially increases the likelihood of violent behavior. In addition, persons with CODs often are homeless, have few social supports, and poor vocational and educational skills, leading to higher rates of criminal recidivism after discharge from an MHC program (Peters et al., 2013). CODs were also found to be major risk factors for rearrest in recent major studies of MHCs (Reich et al., 2015; Steadman et al., 2014).

One new direction of research is confirming the best treatment for CODs. Current findings indicate that offenders with CODs generally are referred to a sequential or parallel form of service delivery (i.e., one disorder is treated at a time or in a parallel manner with different providers). However, outcomes of sequential or parallel treatment models reportedly lead to elevated risk for recidivism (Rojas & Peters, 2016). An integrated treatment method—treating both disorders as primary, focusing on the interactive nature of the disorders, and using a single provider or integrated team—is considered the best practice (Rojas & Peters, 2016; Steadman et al., 2013). One example of such an approach is Illness Management and Recovery, which combines CBT and motivational interviewing and focuses on psychosocial functioning, problem solving, and emotional regulation (Substance Abuse and Mental Health Services Administration, 2009).

Randomized controlled studies and comparisons with standard mental health or substance use treatments are needed to evaluate the effectiveness of integrated treatments for MHC defendants with CODs (Rojas & Peters, 2016). There is a particular need to discern which components are most effective in treatment and to clarify how intense the services need to be for offenders at high risk for recidivism. Finally, more research is needed to understand the factors related to negative termination and non-participation in MHCs, particularly for defendants with substance use histories (Dirks-Linhorst et al., 2013).

Conclusion

When MHCs began, a driving premise was that untreated mental illness and criminal behavior were linked, and effective treatment of mental illness would lead to a decrease in criminal behavior. This viewpoint was tied to the idea of therapeutic jurisprudence; that is, criminals should be rehabilitated through treatment rather than punishment (Hughes & Peak, 2012). However, Skeem et al. (2015) suggested that this premise is “a myth...because mental illness rarely leads directly to criminal behavior” (p. 917). Consequently, they recommend that more emphasis needs to be placed on understanding “the interplay between criminogenic needs and mental illness” (p. 920). Thus, although there is current evidence that MHCs work to reduce recidivism, there is also a critical need to better understand which individuals are most likely to benefit from treatment and which treatment factors are most likely to lead to positive outcomes.

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